ROANE GENERAL HOSPITAL/ RURAL HEALTH CLINICS
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Identification
Printed Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Telephone: _____

1. The following organization is authorized to disclose the above named individual's protected health information as described below. **ROANE GENERAL HOSPITAL**

2. The following person or entity is authorized to receive and/or use the protected health information:

   Name: _____ Telephone: _____

   Address: _____

3. The specific information to be disclosed is as follows:

   Covering the periods of health care:
   From (date) _____ to (date) _____
   From (date) _____ to (date) _____

   Please check type of information to be released:

__ History & Physical	__ Discharge Summary	__ Consultation reports	__ EKG
__ Operative Report	__ Progress notes	__ Lab Results	__ EEG
__ Complete health record	__ X-ray reports	__ X-ray films/images	__ Clinic Notes
__ Photographs, videotapes	__ Complete billing record	__ Itemized bill	__ PT Notes

   Other, (specify)_____

4. **Purpose of Request**
   __ Treatment or consultation __ At the request of the patient
   __ Billing or claims payment Other, (specify) _____

5. This authorization expires in ninety (90) days unless otherwise specified: _____ (expiration date)
6. I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information.
7. I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed to other individuals or institutions and no longer protected by these regulations.
8. I understand that I may inspect and receive a copy of this authorization.
9. I understand that RGH will not refuse to treat me simply because I do not sign this authorization.
10. I understand that I may revoke this authorization at any time in writing, except where action has already been taken in reliance upon this authorization. The written revocation may be sent to:

Privacy Officer, 200 Hospital Drive, Spencer, WV 25276

I authorize Roane General Hospital to use and disclose the protected health information as specified above.

Signature: _____ Relationship to Patient: _____ Date:___/___/___
(*Patient, parent if minor child, or legal guardian)*

_____ Witness: _____ Date:___/___/___
(Printed Name of Patient or Personal Representative)

OFFICE USE ONLY: MR#: _____ ID Verification: __Yes Driver's License#_____ Other_____

Date Released: _____ # Pages Released: _____ Method of Release: ____Mail ____Fax ____CD ____Hand Delivered (Rev. 08/12)